Chapter 1

Shortly after New Orleans physician Samuel Cartwright discovered a new disease in 1850, he realized that like all medical pioneers he faced a special burden. "In noticing a disease not heretofore classed among the long list of maladies that man is subject to," he told a gathering of the Medical Association of Louisiana, "it was necessary to have a new term to express it." Cartwright could have followed the example of many of his peers and named the malady for himself, but he decided instead to exercise the ancient Greek he'd learned while being educated in Philadelphia. He took two words—*drapetes*, meaning "runaway slave," and the more familiar *mania*—and fashioned *drapetomania*, "the disease causing Negroes to run away."

The new disease, Cartwright reported in *The New Orleans Medical and Surgical Journal*, had one diagnostic symptom—"absconding from service"—and a few secondary ones, including a sulkiness and dissatisfaction that appeared just prior to the slaves' flight. Through careful observations made when he practiced in Maryland, he developed a crude epidemiology and concluded that environmental factors could play a role in the onset of drapetomania.

> Two classes of persons were apt to lose their Negroes: those who made themselves too familiar with them, treating them as equals; and on the other hand those who treated them cruelly, denied them

> the common necessaries of life, neglected to protect them, or frightened them by a blustering manner of approach.

But the most evenhanded treatment would not prevent all cases, and for those whose illness was "without cause," Cartwright had a prescription: "whipping the devil out of them."

Lest anyone doubt that drapetomania was a real disease—and, evidently, some Northern doctors did—Cartwright offered proof. First of all, he said, we know that Negroes are descended from the people of Canaan, a name that means "submissive knee-bender," so it's clear what God had in mind for the race. And in case a reader subscribed to the notion, taught in the "northern hornbooks in Medicine," that "the Negro is only a lampblacked white man . . . requiring nothing but liberty and equality—social and political—to wash him white," Cartwright called as witnesses the prominent European doctors who had "demonstrated, by dissection, so great a difference between the Negro and the white man as to induce the majority of naturalists to refer him to a different species." Africans' blood was darker, he said, and "the membranes, tendons, and aponeuroses, so brilliantly white in the Caucasian race, have a livid cloudiness in the African." This historical and biological evidence, Cartwright concluded, proved that running away is neither willfulness nor the normal human striving for freedom, but illness plain and simple.

Drapetomania was never considered for the *Diagnostic and Statistical Manual of Mental Disorders*, the American Psychiatric Association's compendium of mental illnesses, but that may be only because there was no such book in 1850. (Indeed, the Association of Superintendents of American Institutions for the Insane, the organization that eventually became the APA, was only six years old at the time, and the word *psychiatry* had just come into use.) Certainly it met many of the criteria for inclusion. It was a condition that caused distress for a certain group of people. It had a known and predictable onset, course, and outcome.

Its diagnostic criteria could be listed in clear language that a doctor could use, for instance, to distinguish normal stubbornness from pathological dissatisfaction, or to determine whether a slave was running away because he was sick or just evil. Many people besides Cartwright had observed it. Its discovery was announced in a respected professional journal. Its definition was precise enough to allow other doctors to develop tests that distinguished normal (or, as the DSM puts it, *expectable*) from disordered dissatisfaction, and to conduct research that confirmed (or didn't) that most runaway slaves had been sulky prior to absconding, or that slaves treated too familiarly or too cruelly were more likely to contract drapetomania, or that whipping prevented the disease from running its full course. Still other doctors might have recommended potions that would relieve its symptoms. As the years wore on, some doctors might have objected that the disease pathologized a normal response to atrocious conditions, while others might have fought bitterly and publicly over smaller issues: whether or not *defiance* also belonged on the list of criteria; whether to add Dr. Cartwright's other discovery, *dyaesthesia aethiopica*, the malady causing slaves to "slight their work," to the diagnostic manual; which gene predisposed slaves to drapetomania and dyaesthesia; where the thirst for freedom could be found in the brain; and, perhaps, whether or not these were real illnesses or only constructs useful to understanding what Dr. Cartwright called the "diseases and physical peculiarities of the Negro race."

Dr. Cartwright's disease, in short, and the promise it held out—that a widely observed form of suffering with significant impact on individuals and society could be brought under the light of science, named and identified, understood and controlled, and certain thorny moral questions about the nature of slavery sidestepped in the bargain—might have spawned an entire industry. A small one, perhaps, but one that would have no doubt been profitable to slave owners, to doctors, maybe even to slaves grateful for their emancipation from their unnatural lust for freedom—and, above all, to the corporation that owned the

right to name and define our psychological troubles, and to sell the book to anyone with the money to buy it and the power to wield its names.

Even if you're one of the many people who are suspicious of psychiatry and skeptical of its claims to have identified the varieties of our suffering and collected them in a single volume, you might be thinking that I'm not being entirely fair here, that even if the Civil War hadn't come along ten years later and rendered Cartwright's outrageous invention moot, doctors would have quickly consigned drapetomania to the dustbin of medical history. You might point out that even at the time sensible people objected—Frederick Law Olmsted, for instance, whose *Journeys and Explorations in the Cotton Kingdom* includes a mordant account of "the learned Dr. Cartwright" and his diseases, and the unnamed doctor who satirized Cartwright in the *Buffalo Medical Journal* by suggesting that drapetomania occurs when "the nervous erythism of the human body is thrown into relations with the magnetic pole . . . thus directing [the slave's] footsteps northward." You might say that in introducing a book about the DSM with an anecdote about a diagnosis that is so obviously specious, and in implying that this is somehow emblematic of the diagnostic enterprise, I am taking a cheap shot.

And you may be right.

On the other hand, especially if you are a gay person, you might not be so quick to think that drapetomania is merely a low-hanging cherry that I've picked to flavor my tale. Because you might be old enough to remember back forty or fifty years, to a time when homosexuality was still listed in the DSM. Which meant that doctors could get paid to treat it, scientists could search for its causes and cures, employers could shun its victims, and families could urge them to seek help, even as gay people conducted their intimacies in furtive encounters, lived in fear and shame, lost jobs, forwent careers, and chained

themselves to marriages they didn't want. They underwent countless therapies—shocks to the brain and years on the couch, behavior modification and surrogate sex, porn sessions that switched from homo to hetero at the crucial moment—in desperate attempts to become who they could not be and to love whom they could not love, to get free of their own deepest desires, all in the name of getting well. And all this, at least in part, because a society's revulsion had found expression in the official diagnostic manual of a medical profession, where it gained the imprimatur not of a church or a state, but of science. When doctors said homosexuality was a disease, that was not an opinion, let alone bigotry. It was a fact. When they wrote that fact down in the DSM, it was not a denunciation. It was a diagnosis.

Or maybe you're among the 11 percent of the U.S. adult population whose daily regimen includes taking a dose or two of Lexapro or Paxil or some other antidepressant, and you've been doing that for years, ever since a doctor told you that you had Major Depressive Disorder (or maybe she just said you had clinical depression), meaning that your sulkiness and dissatisfaction were symptoms of a mental disorder, and that this was a chemical imbalance that those drugs would fix. And maybe they did, because at least for a little while you felt better; but then you got tired of feeling numb, of gaining weight, of not wanting sex and not being able to have an orgasm even if you did; and then you tried to get off the drugs only to find that your brain off drugs is an unruly thing, that your old difficulties returned or new ones arose when you stopped taking them. Which might mean, you told yourself, that you indeed have that disease, but every once in a while—when you read about the placebo effect, or you hear that this chemical imbalance does not, as far as doctors know, really exist, or when you look at the DSM and realize that there are more than seventy combinations of symptoms that can result in this one diagnosis and that any two people with the diagnosis may have only one symptom in common—you wonder whether what your doctor told you is true and whether you have now

changed your brain chemistry, perhaps irreversibly, to cure a disease that doesn't exist.

Or maybe you're a parent of a child who drove you to despair with his tantrums and defiance, whom you took to doctor after doctor until finally you found the one who told you that he had Bipolar Disorder, but that this was really good news, because that disease could be cured with a daily dose of Depakote or Risperdal. And sure enough, your kid calmed down, but now he weighs twice what he should and there's sugar in his urine and dark circles under his eyes, and you're beginning to think—especially since you heard about how drug industry money influenced doctors to make that diagnosis and how pharmaceutical companies still haven't fully tested these drugs on children and how doctors massaged those diagnostic criteria to fit your kid—that maybe your psychiatrist was wrong when he said that Bipolar Disorder is the same kind of disease as diabetes, a chemical problem that you leave untreated only if you are a bad parent.

Or maybe you're like me—a mental health professional who has been faithfully filling out insurance forms for thirty years, jotting down those five-digit codes from the DSM that open the money taps, rendering diagnoses even though you are pretty sure you're not treating medical conditions, and for just a moment you hesitate, contemplating the bad faith of pouring a lie into the foundation of a relationship whose main and perhaps only value is that it provides an opportunity to look someone in the eye and, without fear of judgment or the necessity to manipulate, speak the truth. And, having contemplated it, you tell yourself whatever story you have to and you sign the paper, and the best you can do is to curse the DSM in a kind of incantation against your own bad faith.

Or maybe you've never had truck with the mental health industry, but the other day you were talking with a friend and explaining to her that you had to wash your dishes before you could leave your house, and

you found yourself saying, "I'm just so OCD, you know?" Or you've heard your friends do the same thing with their own or others' quirks. "He's pretty ADHD," they might say. Or, "She's clinically depressed." Or, "Sorry, that's just my PTSD." And maybe you've been brought up short by the way the DSM's lingo has infiltrated our self-understanding or wondered what it says about us that we describe the habits of our hearts in a pastiche of medical clichés.

If you are one of those people, which is to say if you have had occasion to take the DSM seriously (and even the book's most ardent defenders will tell you this was your first mistake), then you may be sympathetic to my rhetorical move. You may understand that Dr. Cartwright did what he did because he could, because the power to give names to our pain is a mighty thing and easy to abuse. Cartwright seems to have intended to serve the interests of slave owners and white supremacists and their economic system by providing "another [of] the ten thousand evidences of the fallacy of the dogma abolition is built on," but surely the doctors who insisted that homosexuality was a disease were not all bigots or prudes. Nor are the doctors who today diagnose with Hoarding Disorder people who fill their homes with newspapers and empty pickle jars, but leave undiagnosed those who amass billions of dollars while other people starve, merely toadying to the wealthy. They don't mean to turn the suffering inflicted by our own peculiar institutions, the depression and anxiety spawned by the displacements of late capitalism and postmodernity, into markets for a criminally avaricious pharmaceutical industry.

The prejudices and fallacies behind psychiatric diagnoses, and even the interests they serve, are as invisible to all of us, doctors and patients alike, as they were to Dr. Cartwright's New Orleanian colleagues or to all those doctors who "treated" homosexuals. The desire to relieve suffering can pull a veil over our eyes. And sometimes it takes an incendiary example or two to rip that veil away.

So I apologize for my cheap shot. I apologize to the epidemiologists and sociologists alarmed by ever-rising rates of mental illness and disability; and to the patients who have benefited from a diagnosis; and to the interested civilians who have the intuition that there is such a thing as mental illness, that it belongs under the purview of medicine and that as such it ought to be cataloged, whatever the difficulties; and to the doctors who can argue cogently that the advantages of doing so far outweigh the costs. I apologize to the reasonable folks who think, reasonably, that the DSM is the culmination of a lot of honest hard work by smart and well-intentioned people doing their best at an impossible task, and that it should be given the benefit of the doubt. I apologize to the people who acknowledge that even if the DSM is not the Bible it's cracked up to be, it still, as the backbone of a medical specialty that has done yeoman service, deserves its authority over our inner lives.

But that doesn't mean I'm sorry. By *apologize*, I mean what the ancient Greeks meant. I mean to explain. Because I think drapetomania is not a historical novelty or an anomaly or an accident. It is not the exceptional error that proves the rule that science is self-correcting and will ultimately punish arrogance and incompetence. The story of drapetomania is a cautionary tale, just as the ones about homosexuality and childhood Bipolar Disorder are, and just as the story about a disorder that sits quietly today in the DSM-5 (my vote is for Internet Use Disorder) will be in some tomorrow. All these stories tell us why our inner lives are too important to leave in the hands of doctors: because they don't know as much about us as they claim, because a full account of human nature is beyond their ken.

While I'm explaining myself, let me tell you a story.

In 2012, I got a voice-mail message from a former patient; I'll call him Sandy. I last saw him about ten years ago. I'd worked with him from the time he was in his junior year in high school until he finished

his graduate studies. He'd been plagued by anxiety so severe that he was unable to attend school and, eventually, to leave his house at all. Early on in therapy, he'd told me that he was sure he was gay, and that this was what had led him to hole up in his room contemplating suicide as the preferable alternative to what his parents and pastor, who hadn't deleted homosexuality from their book of sins, called "the gay lifestyle." We talked about this, and more generally about what therapists and patients talk about: parents, friends, regrets, confusion, and fear. I can't tell you why, but therapy worked, at least enough to get him to overcome his self-loathing and his parents' disapproval and to come out, in all senses of that phrase. Last I knew, he had a job and a life in a faraway city. He could work, love, and stay alive, which, by my lights, is about all we can ask for. He kept in touch sporadically via e-mail or phone to tell me what he was up to or to let me know he'd seen something I'd written in a magazine.

The message went like this:

"I know I shouldn't call you, and I promise I won't call you again. But you've got to help me. They've sucked all the bones out of my body. I'm here in this hotel room and my bones are gone. My mother and my father and James. They've done this to me. And I don't want to die. Please don't let them kill me. Don't let them. You're the only one who can help. You know I love you, and I love Ellen Goldstein, too. Good-bye. Good-bye." (I made up those names.)

He didn't leave a number, but according to caller ID, he was calling from a Holiday Inn a thousand miles from where, as far as I knew, he had last been living. Sandy had checked out by the time I tried to return the call. I don't know where he went next. But I am pretty sure about one thing: his parents and James, whoever he was, did not suck the bones out of his body, and they probably weren't about to cook Sandy up in a stew, or whatever he was sure they were going to do. I would guess they didn't even know where he was. I'm not even sure Sandy knew where he was. As I write this, I still don't know what became of him.

Now, if you're like me and most everyone I know, the first thing that you think when you hear a story like this is that Sandy is mentally ill. But what do we mean when we say this?

The first answer is that he is crazy. That is, he is behaving in a way that is abnormal, bizarre, out of touch with reality. The technical term here is *psychotic* or *delusional*. I think this is self-evident, and even if I didn't care about Sandy, I wouldn't think it is benign, a sane response to an insane world, say, or some salutary plunge into the collective unconscious. He was in trouble; he was, as the current jargon goes, *dysfunctional*; his inner life had gone haywire; he needed help.

But what kind of trouble? And what kind of help?

This brings us to the second answer: that his craziness is best understood as the manifestation of a disease that is medical in nature, that is in some essential way no different from all the other diseases that afflict us, and that is best left to doctors to understand and treat.

We have become accustomed to thinking of *disease* in a very specific way: as a pathology of the body, something gone wrong in our tissues or our cells or our molecules. You secrete too much of this or don't produce enough of that, or the rate of the other thing is too high or low, and that is why you can't walk up stairs without losing breath, or why you are in pain or are losing weight, and why, if you don't do what the doctor says to do, if you don't take his pill or let him plunge his scalpel into your skin or drip poison into your veins, you will continue to suffer, or your suffering will get worse, or you will die.

But before you will submit to the cure, you have to believe that the doctor knows something about your pain that you do not, that she can identify that disease, that she is on familiar terms with it, that she knows it by name. She must, in other words, give you a diagnosis.

Diagnosis, not unlike *drapetomania*, comes from two Greek words, meaning "to learn" and "apart." It is a knowledge that sorts one thing from another. The Greeks understood how hard it is to parse the world, especially when it comes to complex experiences. "Love is a madness,"

Socrates tells Phaedrus, and to understand that madness, to untangle it from other experiences, he says that two principles must be upheld. "First, the comprehension of scattered particulars in one idea" that is clearly and consistently described. But, Socrates continues, we can't gather the particulars together under just any idea. No matter how vividly described or comprehensive the categories, and no matter how well they seem to cohere, they must also be fashioned "according to the natural formation, where the joint is, not breaking any part as a bad carver might." A good diagnosis must be more than the fancy of the diagnostician, more than merely deft. It must also be accurate. It must carve nature at its joints.

What is true for the madness that is love is true for any madness at all—or, for that matter, any suffering that doctors purport to understand. The diagnostician's job is to find the disease that unites the scattered symptoms and makes them manifest in precisely the way they do, to say with certainty that this distress is the result of that illness and no other. The diagnostic enterprise hinges on an optimistic notion: that disease is part of a natural world that only awaits our understanding. But even if this is true, nature gives up its secrets grudgingly, and our finite senses are in some ways ill suited to extracting them. More important, our prejudices lead us to tear nature where we want it to break. Science, especially modern medicine, is founded on this equally optimistic idea: that experts can purge their inquiry of prejudice and desire, and map the landscape of suffering along its natural boundaries.

Greek doctors, as it turned out, were not so good at this. They had some ideas about what those natural formations were, largely having to do with four bodily humors—blood, bile, phlegm, and melancholy—that, if thrown out of balance, could cause illness. But humoral theory was more metaphysics and wishful thinking than truth. Even Hippocrates and his disciples seemed to know this, as they traded mostly in *empiricism*—the painstaking observation of the way symptoms

appeared to the doctor's senses, the courses they took, the outcomes they reached, and the interventions that affected them.

In the nineteenth century, most doctors still believed that humoral imbalances caused disease. Before John Snow could persuade the local government to close the infected well that caused the 1854 cholera outbreak in London, he had to overcome the common idea that the disease was carried by a *miasma*, bad air that could upset humoral balance. Louis Pasteur and Robert Koch had to work hard to convince their colleagues that germs caused diseases like rabies and anthrax, and that they (the germs, not the colleagues) could be targeted and killed. As the microscope and the chemical assay provided incontrovertible evidence of germs and their destruction, doctors were won over to the germ theory, and soon it seemed that they had begun to fulfill Socrates' dictum to find the natural joints that separated our ills from one another.

By the turn of the twentieth century, doctors were stalking disease like Sherlock Holmes stalked criminals. Under the magnification of their microscopes, syphilis, diabetes, and streptococcus, to name just a few, soon yielded their secrets and their terrifying hold on us. With their newfound ability to parse suffering, to track it down to the bodily processes causing it, and then to dispatch it with a potion or a surgery, doctors gained prestige—and with it, money and power. They were rewarded as much for their prowess in relieving suffering as for the promise they now embodied: that they could use science to give a name to someone's suffering and then, having named it, to relieve it.

This revolution in medicine accounts in part for the immense appeal of considering craziness to be just another disease. If scientific understanding and cure were possible for the suffering of the body, then why not for the suffering of the mind? If Sandy's conviction that his bones have been sucked out of his body is some kind of metaphor, if the content of his delusion brims with meaning—an expression of impotence, a lack of backbone, an inability to hold himself up—then it is out of the reach of the microscope and the X-ray. It requires what the ancient

doctors offered: interpretation and the invocation of metaphysics, of something beyond the symptom. But if the delusion is only another symptom, if it is not, in principle, different from the malaise and relentless thirst of an untreated diabetic, or the narrowing of vision of a glaucoma patient, or the fever of someone with malaria, then it can be brought under the physician's purview. It doesn't need to be understood in itself any more than fever or thirst does. It can be explained, it can be treated, and it can be cured.

If you've gotten sick or injured and a doctor has restored you to health or if you've seen this happen to someone else—and who hasn't?—then you know the lure of this promise. If you've watched your child descend into psychosis or your husband spin out into mania or yourself struggle to get off the bed onto which depression has laid you, then you know it even better.

On the other hand, if you've been involved with the mental health industry, then you probably also know that the promise is not always fulfilled. Even if doctors can settle on a name for Sandy's illness—and this is not a sure thing; they are likely to be torn between Schizophrenia and Bipolar Disorder—they will not be able to scratch out a prescription, tell him to take two and call in the morning. He may end up taking a drug indicated for a different diagnosis, or a cocktail of pills—one to quell his hallucinations, one to temper his agitation, one to relieve his depression, and one to help him sleep—and the combination may change monthly or even weekly, or it may work for a while and then stop. No one will be able to explain why that happened, any more than they will be able to explain why the drugs worked in the first place. No honest psychiatrist will claim that she cured Sandy's, or anyone's, mental illness; and while she is being honest, she may acknowledge that, for the most part, her treatments are targeted at symptoms, not diseases, and that she selects them as much by intuition and experience as by scientific evidence.

But psychiatry's appeal is not just about the possibility of cure,

which is why the profession continues to flourish even when it cures nothing and relieves symptoms only haphazardly. It's in the naming itself. What Wallace Stevens called the "blessed rage to order" is so deep in us that it is in our origin story: the first thing the Bible's authors have Adam and Eve do to establish their dominion over Eden is to name its flora and fauna. That story doesn't have a happy ending, and neither does the one I'm about to tell you (although in the latter case, there is good reason for that). But the rage itself is surely blessed, or at least as blessed as we humans can be, and as noble. Give a name to suffering, perhaps the most immediate reminder of our insignificance and powerlessness, and suddenly it bears the trace of the human. It becomes part of our story. It is redeemed.

But what kind of story? And what kind of names?

The DSM-IV, the most recent edition of the manual,* sorts psychiatric problems into chapters like "Mood Disorders" and "Feeding and Eating Disorders" and from there into individual illnesses like Major Depressive Disorder (MDD) or Bulimia Nervosa, each of which might have its own specifiers, so that a complete diagnosis might read Major Depressive Disorder, Recurrent, Severe, with Melancholic Features. For each disorder, criteria are listed. There are, for instance, nine criteria for a Major Depressive Episode; if you meet five of them, then you have fulfilled the necessary condition for that diagnosis; and if you meet four others in addition, then you have sufficient symptoms to earn the MDD label. In addition to the criteria, the DSM supplies *text*, a not-quite-narrative account of the prevalence, family and gender patterns, and other associated features of the disorder, and instructs doctors how to differentiate among disorders that resemble one another. Depending on

*Since the first DSM, published in 1952, there have been three major revisions: DSM-II (1968), DSM-III (1980), and DSM-IV (1994). There have also been two interim revisions, more limited in scope: DSM-III-R (1987) and DSM-IV-TR (2000). The DSM-IV-TR is the edition in effect until DSM-5 is released. For brevity, I will refer to this current edition as DSM-IV.

how you count—whether or not you consider each subtype its own disorder, for instance—the DSM-IV lists around three hundred disorders in its nearly one thousand pages.

You could think of the DSM as a handbook designed to help doctors recognize the varieties of psychological travail, not unlike the way Audubon's field guides help ornithologists recognize birds. You could think of it, as some people (especially its critics) do, as the Bible of psychiatry, providing a scriptural basis for the profession. You could think of it—and this is what the APA would like you to do with the DSM-5*—as a living document, akin to the U.S. Constitution, a set of generalizations about the present, flexible and yet lasting enough to see an institution into the future. Or you could think of the DSM as a collection of short stories about our psychological distress, an anthology of suffering. You could think of it as the book of our woes.

All of these work; I favor the last one, but then again, I'm hardly unprejudiced, and even I have to admit that the DSM barely qualifies as literature. It's lacking in plot, and it bears all the traces of having been written by committee; it is, as Henry James said of the nineteenth-century novel, a "loose, baggy monster." But then again, unlike the works of Tolstoy and Thackeray, the DSM belongs to a genre that is forgiving of poor writing, that ends up inviting and rewarding it. The book avoids the Latinate jargon that physicians tend to favor, but it is written by doctors and designed to be used in medical offices and hospitals around the world; it is a medical text. Which, nowadays anyway, means it is a scientific text, one that casts its subjects into dry, data-driven stories, freed from the vagaries of hope and desire, of prejudice and ignorance and fear, and anchored instead in the laws of nature.

*After the DSM-5 revision got under way, the American Psychiatric Association decided to abandon Roman numerals in favor of Arabic. I will be using the Arabic throughout, but some quoted material from early in the process will use Roman.

I'm not sure that this is the right genre for understanding us, and I'm not alone in my doubts. Psychiatry didn't always have dominion over the landscape of mental suffering, at least not the kind that shows up in everyday life. Psychiatrists, once known as "alienists," originally presided over asylums housing people too crazy to function outside them. The treatments the doctors doled out, if they doled out any at all, varied from hospital to hospital and took place largely out of the view of polite society. Psychiatrists did not appear on television to give relationship advice. They did not suggest ways to beat the winter blues. They did not prescribe cocktails of psychoactive drugs to accountants and schoolteachers while telling them what they suffered from.

Not that there weren't doctors doing those things or their equivalents. But most of them were neurologists like George Beard, who suggested, toward the end of the nineteenth century, that symptoms ranging from "insomnia, flushing, drowsiness, bad dreams" through "ticklishness, vague pains and flying neuralgias" to "exhaustion after defecation" added up to a disease that, in his bestselling *American Nervousness*, he christened *neurasthenia.* Or Silas Weir Mitchell, author of the bestselling *Fat and Blood*, his account of how to treat neurasthenia and hysteria (the details of which I won't go into; just use your imagination on the title and you'll get the idea), who was the inspiration for "The Yellow Wallpaper," Charlotte Perkins Gilman's famous fictionalized account of the rest cure she took at his hands. Or John Harvey Kellogg, who teamed up with his industrialist brother, Will, to introduce America's fatigued brain workers to the wonders of flaked cereals, electric light baths, and pelvic massage. Or Sigmund Freud, whose ideas about intrapsychic conflict as the source of psychological turmoil, which he called neurosis, landed on American soil (along with Freud himself) in 1909.

Whatever the merits of their particular theories, these doctors had

one thing in common. People flocked to them, to the spas where nurses swaddled them for their naps, to the offices where they were shocked or steamed or vibrated, and to the analysts' couches where they disburdened themselves of their family secrets and lurid fantasies. The everyday psychopathology of the masses was a burgeoning and protean market, especially among the swelling ranks of the affluent; and doctors, armed with the authority of the microscope and the pharmacy, had seized it.

The enormous opportunity created by the democratizing of mental illness, and exploited by neurologists, was not lost on psychiatrists. In the first third of the twentieth century, they began to escape the asylum, setting out mostly for private offices, where they, too, began to minister to the walking wounded, mostly by practicing psychoanalysis. Their colleagues/competitors included neurologists, but they also included anthropologists and art historians and social workers—nonmedical people who had been trained in psychoanalysis and had hung out their shingles. Given the ascendant power of medicine, these lay analysts might well have failed to capture much of the market from doctors, but the New York Psychoanalytic Society, dominated by psychiatrists, was not content to wait for the invisible hand to lift them to dominance. In 1926, for reasons it didn't spell out explicitly, it declared that only physicians could practice psychoanalysis.

Back in Vienna, Freud, who had long loathed America as a land of the shallow and unsophisticated, was livid. "As long as I live," he thundered, "I shall balk at having psychoanalysis swallowed by medicine." He spelled out the reasons for his objections in *The Question of Lay Analysis*. Medical education, he wrote, was exactly the wrong training for the therapist's job. "It burdens [a doctor] with too much . . . of which he can never make use, and there is a danger of its diverting his interest and his whole mode of thought from the understanding of psychical phenomena." Instead of learning from "the mental sciences, from psychology, the history of civilization and sociology," Freud wrote, would-be physician analysts would learn only "anatomy, biology and

the study of evolution." They would thus be subject to "the temptation to flirt with endocrinology and the autonomous nervous system," and to turn psychoanalysis into just another "specialized branch of medicine, like radiology."

Steeped in the wrong genre, Freud worried, doctors would not provide the densely layered readings of their patients' suffering that he had offered in his essays on subjects like melancholia and narcissism, in case studies about delusional characters like the Wolf Man and the Rat Man, and in books declaring the significance of the seemingly insignificant, of dreams and jokes and slips of the tongue. They would not try, as analysts surely would, to understand the reason Sandy thought someone had sucked out his bones, as opposed to the infinity of other delusions he could have had. Instead, they would offer the kind of cure suggested in their medical texts, the kind that doesn't care what, if anything, the delusion itself might actually mean.

Freud might not have minded that first DSM, which was issued in 1952, thirteen years after his death. He might have recognized his legacy in the names of the sections—"Disorders of Psychogenic Origin" and "Psychoneurotic Disorders"—and of diagnoses such as anxiety reaction and sexual deviation. He might have been pleased by the literary descriptions, steeped in psychoanalysis, which turned up, for instance, in the definition of *depressive reaction* as the result of "the patient's ambivalent feeling toward his loss." Buoyed by the continued presence in the book's 132 pages of his notion that the mind was a host of inchoate and often contradictory feelings, Freud might have been willing to acknowledge that his forecast of a hostile takeover of psychoanalysis by medicine had been wrong. He might even have admired his descendants for their cleverness in avoiding that fate and yet still claiming the perquisites of the doctor, for having figured out how to have it both ways.

But Freud might also have predicted that it was only a matter of time before the strain between the reductive impulse of medicine and the expansive nature of psychoanalysis raised internal havoc. The problems

began in 1949, before the first DSM was published, when a psychologist showed that psychiatrists presented with the same information about the same patient agreed on a diagnosis only about 20 percent of the time. By 1962, despite various attempts to solve this problem, clinicians still were agreeing less often than they disagreed, at least according to a major study. In 1968, at just around the time the second edition of the DSM came out, research showed that for any given psychotic patient, doctors in Great Britain were more likely to render a diagnosis of manic depression than schizophrenia, while doctors in the United States tended to do the opposite—a difference that was obviously more about the doctors than the patients.

In the meantime, one of psychiatry's own had turned against it. Thomas Szasz, an upstate New York doctor with a libertarian bent, argued in *The Myth of Mental Illness* (1961) that psychiatrists had mistaken "problems of living"—the age-old complaints that characterize our inner lives—for medical illnesses, and the result was a loss of personal responsibility (and a sweetening of the pot for doctors). Also in the early 1960s, Erving Goffman and Michel Foucault, among other academics, chimed in with their view that mental illness was more sociological than medical, and that psychiatrists were pathologizing deviancy rather than turning up genuine illness—which they (along with Szasz) believed existed only in cases where physiological pathology could be identified as the source of the trouble.

The arguments about diagnostic agreement and the nature of mental illness might have remained arcane academic topics had it not been for a Stanford sociologist, David Rosenhan, who, in 1972, sent a cadre of healthy graduate students to various emergency rooms with the same vague complaint: that they were hearing a voice in their heads that said "Thud." All the students were admitted with a diagnosis of schizophrenia, and although they acted normally once they were hospitalized (or normally for graduate students; they spent much of their time making notes, behavior that was duly jotted down in their charts as indicative

of their illness), the diagnosis was never recanted. Some were released by doctors, and others had to be rescued from the hospital by their colleagues, but all were discharged with a diagnosis of Schizophrenia, in Remission.

Rosenhan's recounting of his exploit, "On Being Sane in Insane Places," appeared in the January 1973 edition of *Science*. Later that year, gay activists, including some psychiatrists, after years of increasingly public and contentious debate, finally persuaded the APA to remove homosexuality from the DSM—a good move, no doubt, but one that, especially after what had happened to the graduate students, couldn't help but reveal that even when psychiatrists did agree on a diagnosis, they might have been diagnosing something that wasn't an illness. Or, to put it another way, psychiatrists didn't seem to know the difference between sickness and health.

Forty years, two full rewrites, and two interim revisions of the DSM later, they still don't. Psychiatrists have gotten better at agreeing on which scattered particulars they will gather under a single disease label, but they haven't gotten any closer to determining whether those labels carve nature at its joints, or even how to answer that question. They have yet to figure out just exactly what a mental illness is, or how to decide if a particular kind of suffering qualifies. The DSM instructs users to determine not only that a patient has the symptoms listed in the book (or, as psychiatrists like to put it, that they *meet the criteria*), but that the symptoms are "clinically significant." But the book doesn't define that term, and most psychiatrists have decided to stop fighting about it in favor of an I-know-it-when-I-see-it definition (or saying that the mere fact that someone makes an appointment is evidence of clinical significance). Instead, they argue over which mental illnesses should be admitted to the DSM and which symptoms define them, as if reconfiguring the map will somehow answer the question of whether the territory is theirs to carve up.

This kind of argument leads to all sorts of interesting drama, much

of which you will soon be reading about, but none of it can answer the question I posed about Sandy: Is *disease* really the best way to understand his craziness? How much of our suffering should we turn over to our doctors—especially our psychiatrists?

I don't know the answer to that question. But neither do psychiatrists. Even in a case as florid as Sandy's, they cannot say exactly how they know he has a mental illness, let alone what disorder he has or what treatment it warrants or why the treatment works (if it does), which means that they cannot say why his problem belongs to them. That's no secret. Any psychiatrist worth his or her salt will freely acknowledge (and frequently bemoan) the absence of blood tests or brain scans or any other technology that can anchor diagnosis in a reality beyond the symptoms. What they are more circumspect about is the disquieting implication of this ignorance: that if a physician wants to claim that drapetomania and homosexuality and, as the DSM-5 has proposed, at one time or another, Hypersexuality and Internet Use Disorder and Binge Eating Disorder are medical illnesses, there is nothing to stop him from doing so and if he is shrewd and lucky and smart enough to persuade his colleagues to follow him, the insurers, the drug companies, the regulators, the lawyers, the judges, and, eventually, the rest of us will have no choice but to go along.

So while the psychiatrists who author the DSM and I share an ignorance about how much of our inner travail should be considered illness, only the psychiatrists have the power to decide, and only the American Psychiatric Association claims those decisions as intellectual property that is theirs to profit from. That's why I think you should be more disturbed by their ignorance than mine. After all, if the people who write the DSM don't know which forms of suffering belong in it, and can't say why, then on what grounds can the next instance in which prejudice and oppression are cloaked in the doctor's white coat be recognized? Or, to put it more simply, why should we trust them with all the authority they've been granted?

That's a question that psychiatrist Allen Frances has been asking recently. Frances knows a great deal about power and psychiatry. Indeed, *The New York Times* once called him "perhaps the most powerful psychiatrist in America." That was in 1994, when Frances, who then headed the psychiatry department at Duke University School of Medicine, was chair of the DSM-IV task force, the APA committee responsible for that revision. He's retired now, and not as powerful, but he's a lot more famous, mostly because he has spent the last four years waging a scorched-earth campaign against his successors, largely on the grounds that they are abusing their power. He's warned anyone who will listen that the DSM-5 will turn even more of our suffering into mental illness and, in turn, into grist for the pharmaceutical mill.

Frances is seventy years old, a big, swarthy man with a prominent brow set off by a shock of white hair. I once heard a bartender tell him he looked like a cross between Cary Grant and Spencer Tracy. The bartender may have been flirting or fishing for a bigger tip, but he had one thing right: Frances, like those stars, exudes charm and authority in equal measure. He's soft-spoken, his voice high and reedy, and his patter is compulsively self-effacing, but like certain dangerous animals, he's unpredictable, and always ready to spring.

I hadn't known Frances for very long before he said something to me that he came to regret. It was just before dawn on a morning in August 2010. He'd finished his workout and cracked open his first Diet Coke of the day in the kitchen of the California home he shares with his psychiatrist wife, Donna Manning. The jihad Frances had launched against his former colleagues had made him appealing to magazines like *Wired*, which had sent me to get the skinny on this loyalist denouncing the new regime. Since I'd arrived the day before, he'd been giving it to me, volubly and forcefully; and now we returned to one of the recurring themes of yesterday's conversation: the way the DSM seemed to grant

psychiatrists dominion over the entire landscape of mental suffering, a perch from which they could proclaim as a mental disorder any aberration they could describe systematically. I asked him whether he thought a good definition of mental disorder would establish the bright boundary that would sort the sick from the unusual, and thus keep psychiatry in its proper place.

"Here's the problem," Frances said. "There is no definition of a mental disorder."

I mentioned that that hadn't stopped him from putting one into the DSM-IV, or the people who were then making the DSM-5 from fiddling with it.

"And it's bullshit," he said. "I mean you can't define it."

This was the comment that Frances would come to regret—or at least, when it appeared in the lead of the *Wired* article, to regret having said to me. He soon found himself explaining it—to other writers, to his mildly titillated grandchildren, to attorneys who used it to discredit his testimony as a forensic expert, and, worst of all from his point of view, to Scientologists and other opponents of psychiatry who used it to draft Frances into their cause. Frances never quite blamed me for having turned his words into aid and comfort to the enemy. But even so, he was pretty sore about it, especially, he said, because my use of his words might encourage mentally ill people to go off their medications. I had turned him into my Charlie McCarthy, he complained—not by putting words in his mouth, but by throwing my tone into his voice.

I'm sure Frances would have used a different phrase if he'd thought about it. He didn't intend to dismiss the diagnostic enterprise, let alone all of psychiatry, but rather to say only that it is impossible to find that bright line and probably not worth the bother, that a good clinician can be trusted to determine significance and then, with the help of a decent diagnostic manual, figure out which disorder to diagnose and get on with the treatment. He was shooting from the hip, and even though I don't regret reporting his comment, I can see why he wishes I hadn't.

On the other hand, metaphors often have significance beyond their author's intent, although, as Freud pointed out, sometimes analysis is required to ferret it out. Fortunately for us, there is a philosopher of bullshit. His name is Harry Frankfurt, and he's taught at Yale and Princeton, and in 2005 he published a tiny gem of a book called *On Bullshit*. "Bullshit is unavoidable whenever circumstances require someone to talk without knowing what he is talking about," writes Frankfurt. "Thus the production of bullshit is stimulated whenever a person's obligations or opportunities to speak about some topic exceed his knowledge of the facts relevant to that topic." Filling in the gap between opportunity and knowledge requires the bullshitter to stand "neither on the side of the true nor on the side of the false," he adds. "His eye is not on the facts at all, as the eyes of the honest man and of the liar are, except insofar as they may be pertinent to his interest in getting away with what he says."

For the last fifteen years, some of the smartest psychiatrists in the world, people who have studied diagnosis for their entire careers, people motivated, at least in part, by the desire to relieve suffering, have worked longer and harder, and taken more fire, than they ever expected as they revised the DSM-IV. But if you ask any one of them (and I have asked many) about the DSM's diagnoses and criteria—new and old—he or she will tell you they are only "fictive placeholders" or "useful constructs," the best the profession can do with the knowledge and tools at hand. They are fully aware, in other words, that their opportunity (although they may call it an obligation) to name and describe our psychological suffering far exceeds their knowledge. They have intentionally, if unhappily, stood on the side of neither the true nor the false, and for the sixty years since the first DSM was published, they have gotten away with it.

I don't mean to say that the DSM is nothing more than bullshit, or that the APA is merely trying to hoodwink us in order to maintain its franchise or make a buck (or a hundred million of them, which is what

the DSM-IV has earned it). That would be as glib as tarring the entire diagnostic enterprise with Dr. Cartwright's brush. And as uninteresting: finding bullshit in a professional guild's attempt to strengthen its market position would be no more remarkable than discovering gambling in Casablanca. But what are neither glib nor uninteresting are the circumstances that make it necessary and possible for the 150 men and women on the DSM-5 task force and work groups to have it both ways, to manufacture fiction and yet act as if it were fact. If the story of the DSM-5 has any redeeming value, if it is more than a story about parochial disputes and internecine warfare, it is that it can reveal the conditions that motivate the publication of the DSM and the interests that another revision serves.

Some of those circumstances are straightforward enough, and depressingly banal. If fully 10 percent of your guild's revenue, and an uncountable amount of your authority, depend on a single book, a book that once saved your profession from oblivion and since then has brought it fabulous riches, you don't give it up easily. But other circumstances are less obvious and more dangerous, and the idea that gives psychiatry the power to name our pain in the first place—that the mind can be treated like the body, that it is no more or less than what the brain does, that it can be carved at its joints like a diseased liver—is perhaps the most important of all. It reflects what is best about us: our desire to understand ourselves and one another, to use knowledge to relieve suffering, even if it results in a kind of reductionism that insults our sense of ourselves as unfathomably complex and even transcendent creatures. It also reflects what is worst—the desire to control, to manipulate, to turn others' vulnerabilities to our advantage. The first impulse demands a search for truth at all costs. The second makes it imperative to get away with whatever you can in order to exploit a market opportunity. When those impulses collide, commerce—and often bullshit—will prevail.